Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DANIEL TUFT MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3671-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED, EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided designated doctor services 4/7/11 by determining maximum medical improvement (MMI), impairment (IR), and extent of injury, then billed Texas Mutual $650.00 for this with one unit of code 99456-W5 (Codes 99456-W6 and 99456-MI were also billed but are not at issue in this dispute.) Texas Mutual paid the requestor $350.00 for the MMI exam. The requestor used the lumbar spine DRE category to arrive at the IR…Texas Mutual paid the requestor $150.00 for this. Rule 134.202 at (j)(4)(C) states, 'For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (included feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.' For these reasons no further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. Texas Insurance Code §1305 provides standards for the certification, administration, evaluation and enforcement of the delivery of health care services to injured employees by networks contracting with or established by carrier.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 16, 2011
   - CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - 907 – ONLY TREATMENT FOR THE COMPENSABLE INJURY IS REIMBURSABLE . NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated June 3, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.

Issues

1. Is the respondent's denial adjustment reason codes supported?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The respondent denied the billing with reason code "CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS" and "907 – ONLY TREATMENT FOR THE COMPENSABLE INJURY IS REIMBURSABLE . NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY." The respondent did not clarify or otherwise address or uphold the CAC-B22 or 907 claim adjustment codes upon receipt of the request for reconsideration or in the dispute resolution response, the Division will review the billing per the applicable Division rules and fee guidelines.
2. The requestor billed the amount of $650.00 for CPT code 99456-W5-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and 1 body area was rated, the spine. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The MAR for the Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(I) for the IR using Diagnosis Related Estimates (DRE) Category II method on the compensable lumbar (spinal region) is $150.00. The combined MAR for the MMI/IR services rendered is $500.00.

3. The respondent has previously reimbursed the requestor the amount of $500.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 7, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.